NOTICE OF ACTION ABOUT YOUR MENTAL HEALTH SERVICES

To: *[Name of Medicaid Enrollee]/ Representative (if relevant)* **Date:**
Address
Address

From: Clark County Regional Support Network (CCRSN)
P.O. Box 5000
Vancouver, WA 98666-5000

This is to let you know about an action we are planning to take concerning your Medicaid-funded mental health services that you requested or are currently receiving.

Your (Describe services) _____ **will be:**

- o **DENIED**
  EFFECTIVE DATE _____
- o **REDUCED TO** _____ **FROM** _____
- o **EFFECTIVE DATE** _____
- o **SUSPENDED**
  EFFECTIVE DATE _____
- o **TERMINATED**
  EFFECTIVE DATE _____

The reason for this decision is:

□ You are no longer a resident in the service area.
□ You do not meet medical necessity criteria because
_____.
□ Other:_____

However, you are entitled to a second opinion.

CONTACT PERSON CONCERNING THIS NOTICE: ***Clark County Regional Support Network*** *(CCRSN), Quality Manager, PO Box 5000, Vancouver, WA 98666, 360-397-2130.*

IF YOU DON'T AGREE WITH THIS DECISION, you have the right to appeal. If you choose this right, you have twenty[1] (20) calendar days from the date this notice was mailed to request or file an appeal. Your mental health provider may also file an appeal on your behalf when you ask them in writing. To request or file an appeal, you need to contact: Clark County Regional Support Network, Quality Manager, 360-397-2130 or send your appeal to the address above.

If YOU NEED HELP WITH FILING AN APPEAL you may contact the Clark County Regional Support Network Ombuds Service at 1-866-666-5070. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6388 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

You may also have other persons of your choice assist you during the appeal process. If you want someone else to assist you, you and your authorized representative must sign, date and send us a statement naming that person to act for you.

Before you file an appeal, please see, "Important Information About Your Appeal Rights" on the next page.

[1] If you want to continue to receive your current services during the appeal process, you must file your request within ten (10) calendar days of the receipt of this notice of action.

Denial: The decision not to offer an intake is a denial. The decision by a CCRSN not to authorize covered Medicaid mental health services that meet medical necessity is a denial.

Suspension: The decision by CCRSN to temporarily stop your previously authorized covered Medicaid mental health services described in their Element of Care Guidelines. The decision by a Community Mental Health Agency to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

Reduction: The decision by CCRSN to decrease your previously authorized covered Medicaid mental health services described in their Element of Care Guidelines. The decision by a Community Mental Health Agency to decrease or change a covered service in the Individualized Service Plan is not a reduction.

Termination: The decision by CCRSN to stop your previously authorized covered Medicaid mental health services described in their Element of Care Guidelines. The decision by a Community Mental Health Agency to stop or change a covered service in the Individualized Service Plan is not a termination.

There Are Two Kinds of Appeals You Can File

Standard (45 days) You or your mental health care provider acting on your behalf can ask for a standard appeal. We must give you a decision no later than 45 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Expedited (Fast,3 working days) You or your mental health care provider can ask for a fast appeal if you or your mental health care provider believe that your life, health or major ability to function could be seriously harmed by waiting for a standard appeal. We must decide your appeal no later than 3 working days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If your mental health care provider asks for an expedited appeal for you, or supports you in asking for one, and they indicate that waiting 45 days could seriously harm your health, we will automatically give you a fast appeal.
- If you ask for an expedited appeal without support from your mental health care provider, we will decide if your health requires one. If we do not agree with you, we will decide your appeal within 45 days.

How Do I File An Appeal?

For a Standard Appeal: You, your mental health provider, authorized representative, or an Ombuds should mail or deliver your written appeal to the address below. You may file verbally but, it must be followed in writing.

For a Fast Appeal: You, your mental health provider, authorized representative, or an Ombuds should contact us by telephone or fax at the numbers listed below.

Can I Continue to Receive Services? If you are currently receiving services, your services will be continued during the appeal process when:

- Your appeal is filed within 10 days from the mailed date of the CCRSN Notice of Action.
- Your appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services.
- The current period covered by the authorization has not expired, and the Notice of Action was mailed to you in a timely manner.
- You have requested an extension.

If our decision is not in your favor, you may be asked to pay for the services you received during the appeal or hearing.

What Do I Include With My Appeal?
You should include: your name, address, reasons for appealing, and any evidence you wish to attach. You may send in supporting records, letters from your mental health provider, a list identifying qualified witnesses, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your appeal.

You may send this information to the CCRSN or present this information in person.

WHAT HAPPENS AFTER I FILE AN APPEAL? People from the CCRSN who were not involved in the first decision will review your appeal and provides a written decision within 45 days unless an extension has been requested.

What Happens Next? After the CCRSN makes a decision about your appeal and you do not agree with the decision, you may ask for an administrative hearing through the State Office of Administrative Hearings (1-800-583-8271). You must request a fair hearing within 20 days after you receive the CCRSN decision. You may also access a fair hearing if:

- The CCRSN did not provide a written response within the allowed time frames; or
- You believe there has been a violation of WA State Department of Social and Health Services rules.

Your services may be continued during the Administrative Hearing Process.

Contact Information:
If you need information or help, call us at 360-397-2130.

Other Resources to Help You:
MH Ombuds Service 1-877-397-6465

WA State Department of Social and Health Services Office of Administrative Hearings
P. O. Box 42488
Olympia, WA 98504-2488 1-800-583-8271

NOTICE OF ACTION ABOUT YOUR MENTAL HEALTH SERVICES

To: *[Name of non-Medicaid Individual]/ Representative (if relevant)* **Date:**
Address
Address

From: Clark County Regional Support Network (CCRSN)
P.O. Box 5000
Vancouver, WA 98666-5000

This is to let you know about an action we are planning to take concerning the state funded mental health services that you requested or are currently receiving.

Your (Describe services) _____ **will be:**

- o **DENIED**
  EFFECTIVE DATE _____
- o **REDUCED TO** _____ **FROM** _____
- o **EFFECTIVE DATE** _____
- o **SUSPENDED**
  EFFECTIVE DATE _____
- o **TERMINATED**
  EFFECTIVE DATE _____

The reason for this decision is:

□ You are no longer a resident in the service area.
□ You do not meet medical necessity criteria because:
_____
□ You do not meet the income criteria for state funded services because: _____
□ Other: _____

CONTACT PERSON CONCERNING THIS NOTICE: ***Clark County Regional Support Network*** *(CCRSN), Quality Manager, PO Box 5000, Vancouver, WA 98666, 360-397-2130.*

IF YOU DON'T AGREE WITH THIS DECISION, you have the right to file a complaint or grievance, either verbally or in writing. To file a complaint or grievance, you may contact the mental health agency where you requested services or Clark County Regional Support Network, Quality Manager, 360-397-2130. You may send your written grievance to the mental health agency or to Clari County Regional Support Network at the address above.

If YOU NEED HELP WITH FILING A COMPLAINT OR GRIEVANCE you may contact the Clark County Regional Support Network **Ombuds Service at 1-866-666-5070**. The Ombuds Service is available at no charge to assist you or your representative throughout the complaint or grievance process. You may also call us at 360-397-2130. You may also have other persons of your choice assist you during the complaint or grievance process

If you are hard of hearing or deaf, or have trouble with speech, please contact us through the **Telecommunication Relay Service at 1-800-833-6388 or dial 711**. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

You may ask for an administrative hearing at any time you believe there has been a violation of Washington Administrative Code by contacting:

WA State Department of Social and Health Services Office of Administrative Hearings
P. O. Box 42488
Olympia, WA 98504-2488 1-800-583-8271